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HEALTH SOLUTIONS

Applying a Legacy CQI Process to Our PBHCI Initiative

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Who We Are

- St. Clair County Community Mental Health (SCCCMH), Port Huron, Michigan
- PBHCI Grant Cohort VIII
- SCCCMH Programs Serving Medicaid Beneficiaries (adults, youth) with SMI, I/DD, SUD
- PBHCI Partnership with Lake Huron Medical Center, Port Huron, Michigan

The Focus of Improvement

- A Performance Improvement Project (PIP) within a three-CMH PIHP region focusing on accurate diagnostics and data reporting within programs serving adults with Co-Occurring Disorders (COD), i.e. Serious Mental Illness (SMI), Substance Use Diagnosis (SUD)

- COD Baseline prevalence rate (2007) for persons with SMI = 33%

- PIP prevalence rate target > 50% per Drake (2007), Epstein, et al (2002)

- Initial Root Cause Analysis (RCA) per stakeholder brainstorming, clustering, prioritizing activities suggested issues:

  a) missing SUD diagnoses,

  b)'under'-diagnosing SUD

  c)inaccurate reporting &/or under-reporting of SUD diagnoses in the EHR

The Focus of Improvement

Implemented Quick-Fix Activities:

a) Informing provider system of research-based and MDCH COD prevalence rate expectations,
b) Generating monthly COD prevalence rate reports,
c) Generating weekly diagnostic/demographic reporting Error Reports,
d) Expanding provider program Utilization Review / CAP processes to focus on COD diagnostics

Importance / Why – right treatment / right time / right reasons (i.e., Integrated Dual Disorders Treatment-IDDT)

Organizing the Improvement Team

Key improvement team participants – CMH Clinical Directors, QM/QI Directors, Program Supervisors & SMI/SUD Clinicians, PIHP Coordinating Agency Administrator & Medical Director

Also focus group discussions & consultation with CMH Consumer Advisory groups

Historical Note: this was back in the day when State Dept. of Community Health operated silo-service systems, SMI providers rarely practiced SUD treatment, & appropriate Evidence-Based Practices were still in first-phase implementation State-wide – a somewhat analogous situation to the nation-wide Integrated Health Care today

Our Improvement Plan

- First, complete the PIP RCA (do more consumer and practitioner focus groups, review UR data and explore progress and divergent trends across CMHs, systematize Quick Fix activities that produced results)

- Other causes identified:

  a) staff not sufficiently trained in COD diagnostics and treatment,

  b) staff not sufficiently resourced and trained in the routine use of SUD screening tools,

  c) supervisors not taking on a clinical champion role,

  d) EHR not 'fool-proofing' data entry,

  e) provider programs needed an EBP to lend clinical priority, focus, and longevity

Our Improvement Plan

- Key steps employed in our improvement plan:
  1. Implement Integrated Dual Disorder Treatment (IDDT) EBP
  2. Install new EHR
  3. Create (an informal) IDDT Supervisors' forum and celebrate successes
  4. Implement an IDDT-based staff training structure (e.g. MIN, Staging)
  5. Provide intranet access to SUD diagnostics / screening tools (e.g. AUDIT, MAST, DAST, CAGE)

Impact of our improvement strategies

- Time Fame (2007 – 2012) implemented by the PIHP Quality Management Committee (QMC)

Barriers:

a) *Here we go again, management de jure…*

b) *It'll never work..(and)…I've always done it this way…*

c) *I'm <u>the</u> (part time / locum tenens) psychiatrist and you can't tell me what to do…*

d) *Why can't your just put these tools into the case record so I don't have to waste my time looking for them…*

Impact of our improvement strategies

How did we address these challenges:

a) maintain the top-down support,

b) celebrate the clinical and consumer champions, c) systematize clinical training,

c) strive toward a fool-proof EHR and close-in-time reporting to the end-users **– PIP target (>50%) was achieved and sustained**

- Outcome measurements were mainly comprised of the monthly COD prevalence rate reports, IDDT fidelity reviews / improvement opportunity information, and NOMs tracking, along with other process monitoring

Sustaining improvements and lessons learned

Sustainment Efforts

- EBP expansion and sustainability practices (e.g. Dialectical Behavior Therapy, Family Psycho-Education, In-SHAPE, Motivational Interviewing, Personal Action Toward Health, Wellness Recovery Action Plan)
- EBP and service outcomes policies and procedures
- Annual *Celebrate Recovery* Awards
- Ongoing EHR upgrades

Lessons Learned

- The 1,000-foot Freighter analogy
- One good thing leads to another…

PIP Lessons Applied to Our PBHCI

- Target population is expected to draw from current consumers active in IDDT
- Our SUD provider is also a practitioner within our IDDT and is presently pursuing her certificate in Integrated Behavioral Health and Primary Care (IBHPC)
- Medical practitioners will benefit by our current COD / IDDT training curriculum
  a. Motivational Interviewing (e.g. MIN Applications in the Health Care Profession, MIN for Adults and Children with COD, Supporting Adults and Children in Integrated Health Care)
  b. Stage-Based Assessment and Recovery Principles
  c. Stage-Wise Interventions
  d. COD Psychotropic Prescription Practices
  e. Make it easy-access, case-based (e.g. Brown Bag Lunches format)
- Project Director / Data Manager / SUD provider consider conducting a population analysis for opiate addiction issues, and specialty group therapy 1,000-foot Freighter analogy
- Recalling that one good thing leads to another…

Did you recognize what we did?

As you can see we used, and are using, a **Plan-Do-Study-Act Process!**

Plan: Identified the need/problem and develop a plan

Do: Implement the Plan while gathering data for testing

Study: Check the data to see if the plan worked

Act: Decide to stay with the original plan (b/c it worked) or go back to Plan step and redesign


DISCUSSION
QUESTIONS